



## **Getting Started on the Right Foot**

Host: Rebecca Gillett, MS OTR/L

Guest Expert: Dan Cushman, MD

Feet and/or ankle joints are among the most challenging areas to have arthritis. It can make activities that you love painful and difficult — and if you're athletic or very active, you're at higher risk of developing it. At worst, foot arthritis can be debilitating. And it isn't easy to treat. Joint surgery in feet and ankles can be far more complicated than knee or hip replacements — some of the most common surgeries. The good news is there are more treatment options available today than ever before.

Dan Cushman, MD, who has extensive experience in treating musculoskeletal issues, joins us for this episode to discuss causes and nonsurgical treatments for foot and ankle arthritis, such as corticosteroid shots and rehabilitation exercise.

Dr. Cushman is an associate professor at the University of Utah Department of Physical Medicine & Rehabilitation and the director of non-operative sports medicine research. He is board-certified in both sports medicine and physical medicine and rehabilitation, and specializes in musculoskeletal ultrasound, electrodiagnostics and endurance sports-specific injuries. He serves as the team physician for the University of Utah Track and Field and Cross-Country teams and is also the team physician for the University of Utah Swimming and Diving teams. His research interests include sports epidemiology and musculoskeletal ultrasound for the treatment/prevention of musculoskeletal disorders.

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Episode 57 – Getting Started on the Right Foot  
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**PODCAST OPEN:**

*You're listening to the Live Yes! With Arthritis podcast, created by the Arthritis Foundation to help people with arthritis — and the people who love them — live their best lives. If you're dealing with chronic pain, this podcast is for you. You may have arthritis, but it doesn't have you. Here, learn how you can take control. Our host is Rebecca Gillett, an arthritis patient and occupational therapist, who is joined by others to help you live your Yes.*

**MUSIC BRIDGE**

**Rebecca Gillett:**

This episode, we are talking about our feet and our ankles and our joints in our lower body that we really need to be able to stand up, get out of bed, get moving. And it can be one of the most challenging areas to have arthritis or other foot-related issues because you can't do the things that you need to do or want to do. It makes it very painful and difficult. And if you're athletic or very active, you're at a higher risk of developing issues with your feet and ankles. At worst, foot arthritis can be debilitating, and it is not easy to treat. Joint surgery in feet and ankles can be far more complicated than knee or hip replacements.

Dr. Dan Cushman joins us today. Daniel Cushman is board-certified in sports medicine and physical medicine and rehabilitation and specializes in musculoskeletal ultrasound and electro diagnostics. An endurance athlete himself. Dr. Cushman treats athletes as well as non-athletes. He takes a conservative approach to treatment revolving around the use of exercise as medicine and avoiding medications when possible. He's a team physician for the University of Utah track and field and cross-country teams and swimming and diving teams and is the director of non-operative sports medicine research at the University of Utah. Dr. Cushman, thanks for joining me.

**Dr. Daniel Cushman:**

Yeah, thanks for having me.

**Rebecca:**

Could you tell us a little bit about yourself and some research you might be doing?



Dr. Cushman:

I kind of have a 50/50 split between doing research and clinical work. My clinical work revolves a lot around using ultrasound, which we use nowadays. I think people know it most for looking at babies, but we actually use it a lot for looking at everything under the skin. So, for the feet and ankle, for example, you can see the tendons, you can see everything that's above the bones. You can even see arthritis outside of the joint, that type of thing.

I'm mostly looking to see if we can prevent injuries with ultrasound. And hopefully we can identify problems before they become painful. But I also do a lot of research just revolving around what we do clinically day to day and ways we can make things less painful and ways we, as doctors, can kinda make things more comfortable for patients and safer.

Rebecca:

How much of your focus is on arthritis?

Dr. Cushman:

Maybe a quarter of it or so involves arthritis. But we're starting to expand out a little bit more in our group. One of the projects we're starting to work on is seeing if there's kind of a low-cost alternative to steroids. I know cortisone, corticosteroids, steroids, it's all the same thing. They definitely have their place, but they have some disadvantages as well. So, we're trying to see if there's some low-cost alternatives. Right now, a lot of the alternatives are kind of unproven and very expensive. So, that's what we're starting to look into right now.

Injections are a common treatment for arthritis in really any joint. One of the problems is... I'm sure everybody has a friend who says, "I got a cortisone shot. It was the most painful thing in the world." So, one of the projects we're working on right now is identifying what is painful. Seems like a simple thing, but it's actually not so simple. What we're trying to do is look at what causes pain during those procedures. We want to help patients. So, I think we kinda look at it from both sides, and it really is changing what we do in a lot of ways.

Rebecca:

Are you exploring ultrasound-guided injections?

Dr. Cushman:



We're actually kind of a looking at many different kinds of injections. Doing them without ultrasound, doing them with. There's a method called fluoroscopy, which is like a big X-ray machine. We're comparing a lot of 'em to see. Maybe it's actually less uncomfortable if you do it with an ultrasound, because you can watch where your needle goes, as opposed to doing it without. We're trying to find out which one is actually less painful.

Rebecca:

Yeah. I know having had injections in many different joints, some joints are more painful than others when you get 'em. And I imagine that certain joints, like an ankle or a toe, would not be fun. I know I've had steroid injections in my heel for plantar fasciitis — and I have a high pain tolerance — that is no fun at all. That really hurts. But the pain relief I get from it that is, you know, I can walk, and my heels don't hurt anymore. So, thanks for doing research on that.

Dr. Cushman:

I end up doing a lot of injections, just because we work with a lot of foot and ankle surgeons here at the University of Utah, and they're very, very conservative. A lot of times they'll say, "If I have the choice between doing a cortisone shot or a surgery, I'm gonna choose the cortisone shot just in case that does the trick and we don't need a surgery."

Rebecca:

My podiatrist had mentioned that there's a different type of corticosteroid they're using now that seems to be longer lasting. Are you familiar with that?

Dr. Cushman:

There is one that I know of. It's a newer medication. The common corticosteroids that are used nowadays, the cortisones, they've actually been around since I wanna say the '60s. Maybe three years ago, there was a newer cortisone, but what it actually is, is the same cortisone. It really is kinda hard to put it in smaller joints in the foot and that type of thing. And the other thing is, because it comes in these kind of delayed release things, it's very thick. So, it's not like it's a more painful injection. It's just, you can't really get it into tiny joints very easily, if that makes sense.

Rebecca:

That totally makes sense. Let's talk about different causes of foot and ankle pain. How can someone know if it is arthritis?



Dr. Cushman:

I think that there is a wide variety of problems that can occur. And just to be clear for the listeners, there are different kinds of arthritis: There's osteoarthritis, and there's inflammatory arthritis. And arthritis simply means that the joint is inflamed. The most common one by far is osteoarthritis. And that's where the cartilage is kind of wearing down.

It can be in any of the joints. There's lots of little joints in the foot and ankle. It's pretty localized to that area, but it can kind of spread out once it starts getting worse. Some people can have arthritis and have no pain. Some people can have mild arthritis and have tons of pain. It's not necessarily the amount of cartilage wear relates to how painful it is, but as it progresses, it does tend to get more and more painful.

One of the issues is there's also a lot of other stuff there: There's tendons, there's ligaments, there's all these other things in there that could also be causing pain. I think probably the number one complaint would be that it hurts when you bear weight on it. I think that's probably the most common thing. Meaning if I take the weight off of it, it feels better. And as I put more weight on it, it hurts more.

Rebecca:

It might not be your arthritis. It could be another condition.

Dr. Cushman:

Yes.

Rebecca:

What other conditions might somebody be looking to rule out, maybe to determine whether it's your arthritis or another condition?

Dr. Cushman:

There are, I would say, a litany of ways. An X-ray would show if the bones are getting closer together. If you think of the end of a chicken bone, that's cartilage, and that cartilage is gonna bump up against more cartilage in the other bone. And as it wears down, you can't see the cartilage on the X-ray, but you can see those bones getting closer together. So, that is probably the most common thing to help figure out osteoarthritis. Sometimes there's joint swelling and, if that's the case, we oftentimes will try to pull the fluid out of there, and that fluid can give us a lot of clues.



We can get other kinds of advanced imaging like a CT scan or an MRI; those can help us figure out certain things. Hands down, the number one thing is what the patient tells us. Based on what they tell us, when it hurts, how long it's been hurting, what causes the pain, what makes it better, that tends to be more useful than anything else. I would go as far as saying 95% of the time, they'll tell us the diagnosis and then we confirm it with something else.

Rebecca:

That's being patient centered and listening to the patient, so that's great. When I was first diagnosed, I developed a bunion right away, which, when I would flare, that would flare, which would make it difficult for me to walk. I've had plantar fasciitis, which is why I've had injections in my heels. Can you talk about how those different conditions — there's also peripheral neuropathy that people with rheumatoid arthritis might also have — can you talk about some of those conditions?

Dr. Cushman:

Peripheral neuropathy is kind of a catchall term. And it refers to the nerves being sick and not just one nerve. It's not like when you get a pinched nerve in the back or a pinched nerve in the neck. It's all the nerves. And in general, when all the nerves get sick, it starts affecting the longest nerves. So, if you think of two nerves, one nerve being three feet long and one nerve being one foot long, if that whole nerve is sick, the three-foot nerve is gonna feel it more. Because by the time it gets to the very end, more and more and more of it has been sick, if that makes sense.

We start feeling it in the toes first, then it starts making its way up as the neuropathy progresses. They start feeling in the ankles and then the knees. And then by that point in time it's getting to the knees, you'll start feeling it in the fingertips too, 'cause it's about the same length from your back to your knee as it is from your neck to your fingertips. That's what a neuropathy is.

The problem is there are so many things that can cause neuropathy, and I wanna say one-third of all peripheral neuropathies that get diagnosed, we don't figure out why it happens. It's a very common thing. And the most common symptom by far is just numbness and tingling that starts in the toes and works its way up. And it's hard to lift your feet, those types of things.

So, when people start getting numbness, tingling, in their toes pretty evenly, it's starting to go up their foot, definitely worth getting checked out. Some of them are very treatable. Some of them are not. The most common cause is diabetes by far. I would



say I'm guessing that alcohol might be the second most common. The plantar fasciitis that you had mentioned is another very common one. That's pain on the bottom of the heel. It's usually worse first thing in the morning; you take a step, and it hurts like crazy. And then as you walk a little bit, it gets a little bit better, but every step just hurts. It's right on the bottom of your heel, rather than the back of your heel.

The Achilles tendon is the one on the back of your heel. That's another problem. People can get Achilles tendinopathy or tendonitis where the heel itself is really hurting in the back. And the heel cord is the Achilles, and a lot of people will get pain along there. There are other tendons on the inside and the outside of your ankle that can also get inflamed. A lot of people have pain through there. Those are again tendonitis or tendinopathies.

The bunion you had mentioned is where the big toe, if you think of the actual toe itself, it starts moving outwards. The base of that big toe starts moving inwards, and you basically get an angle to it. And that bump that gets created on the inside can be really painful. I think most people have heard of bunion surgery and how rough it is. And there's definitely truth to that.

I think the earlier you can treat it, the better. Sometimes you can treat it conservatively. I'm a huge fan of physical therapy for those kinds of conditions. Sometimes it's too late to do the physical therapy, but early on a lot of times getting the foot muscle stronger can really help a lot with that.

Rebecca:

Are there things you can do to prevent plantar fasciitis and bunions from forming or happening?

Dr. Cushman:

I think there are a few things that we can say will probably help. One would be if there is kind of a repetitive activity you're doing — if you're running, if you're working a job or you have to walk a lot, those types of things — I think most people would agree either having some type of arch support would be good.

My two cents is: I would rather you use your own muscles to support your arch, but I think others would say using an orthotic would help support your arch. I think there's differences of opinion on that, but I think both are very reasonable. So, when you're doing a lot of those, you need to make sure that your feet are, I would say, appropriately supported, either by yourself or by something else.



There is definitely a genetic component to it, where some people are just more prone to it than others. People who have flatter feet tend to put a lot more stress on that arch. Those people need to be a little bit more aware. But other than that, I don't think we have anything that we know really helps. I think a lot of people would say, "Oh, you need good shoes." But 'good shoes' are very subjective.

PROMO:

*The Arthritis Foundation's Walk to Cure Arthritis is back in person! Together, we're raising money for better treatments and a cure for the nearly 60 million Americans with arthritis. Help Rock the Walk. Sign up at <https://www.arthritis.org/events/wtca>.*

Rebecca:

You mentioned physical therapy and exercises for the feet. Can you go in a little more detail about that?

Dr. Cushman:

The concept there is: If you were to look at a diagram of the muscles that control your feet, you've got two sets. You have ones on the bottom of your feet. And I think that's where most people just conceptually envision: If you're moving your toes, that's coming from the bottom of your foot, but you actually have more in your calf. Those are the ones that are probably stronger muscles.

I think we have developed, given our modern society where we wear shoes, where we sit a lot, and we start using those muscles more — and when you use those muscles more and the foot, we call 'em the foot intrinsic muscles — we think that those foot intrinsic muscles just don't work as well. And we get into these habits where we don't even think about that, but we use the big muscles rather than little muscles.

So, if you work with a really good physical therapist, oftentimes they can get those foot muscles stronger, and that will support the arch of your foot better. I think that is a very tough thing to teach, though. A lot of people will say, "Well, can I just look up some videos on YouTube and do it?" Yeah, you can. But the problem is: You usually don't know if you're doing it right or wrong.

Rebecca:

Right.

Dr. Cushman:





The advantage of a good physical therapist is they can say, "You think you're doing it right, but you're actually not," or "You're doing it right, now start progressing it and do something a little harder," or "You are doing it right for this, but you're not doing it right for this." And then the final part of it is: You need to incorporate that into every step you take, which is a hard thing to do. It's almost like relearning to walk, so it's not a very easy process. And it needs somebody with a lot of experience to kinda teach you. But I find that it can be really beneficial.

There's a story of a famous marathoner who was getting a lot of foot pain. And he started to do these types of intrinsic muscle strengthening. And his shoe size went down a size and a half. And it's because, over time, his flat foot started to develop an arch, and it lifted his foot and pulled the toes back. And it really does happen that way, where people who start to develop an arch again, start getting smaller shoes, because their foot is in a more normal state, if that makes sense.

Rebecca:  
That's super fascinating.

Dr. Cushman:  
Yeah.

Rebecca:  
I have never heard any PT talk to me about, you know, doing exercises like that. And mostly it's about stretching. Stretching out your arch or whatever it is versus strengthening of those intrinsic muscles, but it makes a whole lot of a sense. Thanks for bringing that up.

You've talked about OA already, osteoarthritis, and the bone-on-bone and breakdown of cartilage for that. But what about psoriatic arthritis or gout? I know with psoriatic arthritis and axial spondyloarthritis, a lot of times people might have enthesitis. And then, of course, gout, depending on which joints... What are the differences in how those two diagnoses look like?

Dr. Cushman:  
Those fall into what we call inflammatory arthritises. My view of inflammation might differ from your view, which might differ from your friend's view, of what inflammation means. For example, some people would say it's really inflamed. And what they mean by that is it hurts. Other people might say it's really inflamed. And what they mean by that is it's



turning red. True inflammation means that the body is sending a bunch of chemicals there; generally, there's more blood vessels kinda carrying it there.

It's more of a problem with the way of the body healing. For psoriatic arthritis, gout, pseudogout, rheumatoid arthritis, lupus, lots of other types of diseases can cause a true inflammatory arthritis. And I think the main difference is — I don't wanna diminish the amount of pain somebody with osteoarthritis has — but I would say if you average all comers, the inflammatory arthritises are more painful.

I would also argue that the majority of people who have one of those kinda conditions — psoriatic arthritis, gout, rheumatoid arthritis — they are rarely asymptomatic. It's rarely there's something going on and it doesn't hurt like crazy. For the osteoarthritis, there's a lot of people who have it; they don't even know it. You'll find an 80-year-old gentleman who's been working on a ranch his whole life. You take an X-ray, and it looks awful, but he has no pain. He's just able to do everything; he might be stiff, but that's about it.

For the inflammatory arthritis, they tend to be a lot more painful. I won't get into all the medical specifics, but if you pull the fluid out, because they tend to make a lot of joint fluid, that fluid is different. You can tell from that. For gout and pseudo gout, there are actual crystals in the joint, and they hurt. And the body says, "I don't want crystals in the joint." It starts sending in all these inflammatory chemicals and white blood cells and everything to fight it. So, it really, really hurts.

If left untreated, they often will destroy the joint. If you don't do things about it, the joint will get injured. It's not something you should just say, "Oh, I'll see if it goes away."

Rebecca:

What are some of the more common treatments?

Dr. Cushman:

There's a blood test you can do to get some hints as to whether it's gout or not. You can again put a needle in it, pull that fluid out; that can tell you 100% for sure you have gout. Let's say you do that. You pull that fluid out. I think most physicians now will go one of two ways. One is you can treat that gout directly and put cortisone in there. I think that is probably the first-line treatment. The other, though, is you can take a pill. It's an anti-inflammatory; again, this is an inflammatory condition.

You take an anti-inflammatory pill: That often can help, too. I think those would be the two general treatment options. But once you treat the acute issue and get things to



calm down, it doesn't hurt anymore, with gout specifically: There's a pill that's been around for decades that will lower the amount of crystal-creating substances in your body. You can take that pill on a daily basis to prevent the gout from happening again.

And for the psoriatic arthritises, the rheumatoid arthritises, there's a whole host of medications now that can help keep those things at bay. Those are ones where your body is fighting itself, the autoimmune conditions. A rheumatologist has a million tools at their disposal now to try and help prevent it from happening.

Rebecca:

For osteoarthritis, with joints like the knees and the hips, often joint replacement becomes one of the best options. For someone whose feet or ankles are affected, what are some of the options? And at what point would you be considering foot or ankle surgery?

Dr. Cushman:

I think if you have severe osteoarthritis, most surgeons would say still: Try to do something before a surgery. The nonsurgical options would be physical therapy, that honestly is not going to fix most people, but it can help in some; downside to it is cost. But the upside to it is it's really no risk, and it really might help, even if it brings pain down quite a bit, 50%, 75%; sometimes that's enough to save you a surgery.

Second would be pills. Oral NSAIDs, the ibuprofens, Aleves, those kinda things. I'm not a medication fan myself. I just find that often they can have other side effects, and suddenly your kidneys start hurting, and your stomach starts hurting, and you can have heart issues, those types of things. So long term, that's not a really good option, but it can be used. Third would be injections. The vast majority of them are still cortisone injections. They tend to help for a few months and wear off. But occasionally you'll get a patient who will do one, and it helps for four years.

The surgeries for those are usually fusions. That's where you take one bone that's lost its cartilage. It's already bone on bone, and you just push it into the other bone, and it stays with that bone. So, now it's fused, and the pain goes away. But you can't move that joint. In a lot of cases, people couldn't move that joint already because it was bone on bone. For lot of people, it's a great option actually. It makes them feel so much better. But the problem is: Now the other joints have to pick up the slack. So those joints are now moving more, and they can start hurting.



Ankle replacements are not at the place where hip replacements and knee replacements are. It's very surgeon-dependent, I would say. And it has to be the right patient. I'm not the right person to ask about that 'cause I don't do the surgeries, but I would say it's not a slam dunk. However, there are some people who get them, and it was definitely the right call, and they're glad they did. But it's not as easy as saying: Well, you have a bad hip, get a hip replacement.

Rebecca:

Yeah. I mean, it's very subjective, about your pain experience, whether or not you wanna go down that road of the fusion. It's just very personal, I think. I have a friend with osteoarthritis in her feet, and when she saw an orthopedic surgeon, she didn't get very much practical help, according to her. She said a podiatrist was actually more helpful. Can you talk a little bit about how these two disciplines approach treatment differently?

Dr. Cushman:

It probably depends on who the surgeon is, who the podiatrist is. I just am fortunate in that I work with a great group of people. I have a strong bias towards the orthopedic surgeons. There will be some who have a good bedside manner and some who don't. Some surgeons tend to be very surgeony.

For the podiatrist, they have a very different route. They go to podiatry school, so they don't go to medical school, they go to podiatry school. Theirs is much more focused. I think that comes with pros and cons. The big pro would be: They know the foot and ankle really well. That's all they do. The con might be: Let's say there's rheumatoid arthritis as well; they may not have as much of a background in that. They might miss other things that contribute to it.

I just don't work with podiatrists as much. The podiatrists that I have worked with in the past have been great. In general, it's probably more a matter of who you see rather than what you see (laughs), if that makes sense.

Rebecca:

Yeah. It's OK to ask questions and look for a referral for any specialist that you see. I know personally for my podiatrist that I see, my rheumatologist specifically refers to him because she knows he is familiar with rheumatologic conditions. He was able to just do X-rays and listen to what was bothering me and say, "This is more mechanical than it is actually your rheumatoid arthritis." I have orthotics made, and it has made a huge difference, right? But it just depends.



When is it appropriate to use orthotics? Is there a certain type of shoe that I should wear when I'm using an orthotic? I know it doesn't necessarily always fix the problem, but it can alleviate symptoms. Can you speak on that?

Dr. Cushman:

Yeah. My two cents is that it's very person-dependent. I think that when I see a patient, and I say, you should get an orthotic, there might be another doc who sees the same patient, hears the same story, says you shouldn't do an orthotic. And there are physical therapists who would disagree or agree. So, it's very patient-dependent and provider-dependent, I would say. I think big picture, those who have a flat or a high arch are probably more likely to benefit from it than somebody who has a neutral arch.

I am just a believer that the less we can rely on external devices, the happier we are. If I can get somebody to a good physical therapist, and they can get by without an orthotic and everything gets better, to me that's better than somebody who relies on an orthotic for a long time or the rest of their life. I think it's much better than taking ibuprofen three times a day for the rest of your life.

It's a pendulum where I would say, 20 years ago, we said: You need a very stable shoe to support your foot. Then it swung to no, actually you should be barefoot all the time and have the minimalist shoe to make your feet stronger. And now it's swinging back to no, you should have a cushiony shoe.

Rebecca:

Yeah, it's tough. I mean, just like everybody's pain is personal, same thing with this, right? It's gonna be, like you said earlier, who you see and how you feel about it, you know, what you feel like you can manage as the treatment. Is there anything else that we didn't touch on that you feel like we should talk about?

Dr. Cushman:

Yeah, I think the one other thing is: The most common cause of ankle osteoarthritis is a prior injury. Somebody had a trauma, did something to their ankle, and then they develop arthritis years later. For people who have had a pretty significant injury, they might need to be a little more cautious and a little more aware of what they do with their foot or ankle, depending on what happened.

For them, you know... It's not uncommon to have skiers, we see it all the time: a fairly significant fracture of their ankle, and then a year later they're back to normal doing



everything. It's something to just be a little more aware of. If I had my choice... And to me, I don't mind running. I don't mind cycling. They're about the same to me. I would say, choose the cycling. And I don't say that very much. (laughs)

I think running is great for most people, but I think, in some cases, anything you can do to keep in motion and active and everything like that, but minimize the impact as much as possible. I wouldn't avoid running. It's just, if you have all things being equal, I would try the less impact activities. And just above all for those patients: maintaining a good weight. Trying to not be overweight is gonna be better than anything else.

Rebecca:

Yeah, and people get frustrated. They do hear all the time: Manage your weight, lose weight. Can you explain why that's important?

Dr. Cushman:

One is: It's not easy to do, and it's very easy for someone to sit there and say, "Oh, you need to lose weight." Second thing is that, let's say you have ankle pain. It's really hard to lose weight if your ankle hurts on every step. It's kind of this vicious cycle that develops that way. So, I would say things that you can do are: Number one, any activity you do, namely walking, is good. It will not be bad for your arthritis. It will not be bad for anything else. It will make you feel better.

Joints like motion. The more you do from a chemical standpoint and a cartilage standpoint, your joint will respond better. The more activity is good. And then the second thing is just simple physics. The more weight you have, the more weight goes through your ankle. And every step you take, let's say you weigh 150 pounds as an example, when you're standing just by yourself on two feet, you have 75 pounds going through each ankle.

When you walk, you have 150 pounds on your right, then 150 pounds on your left, then 150 pounds on your right. So, you have a lot of weight going through one single joint. Losing five pounds has a huge effect. If you're able to lose 15 more pounds, even better. But even those little things are really helpful and will make a big difference, not just for your physical health, but for your mental health as well. To me, the weight loss is such a key, key thing, but really difficult to do.

Rebecca:

Yeah, for sure. I mean, it's easier said than done, right? Especially coming out of a pandemic.



Dr. Cushman:  
Yeah.

PROMO:

*Want to learn more about how to live your best life with arthritis? Check out the Arthritis Foundation's e-books, including tips for dieting, traveling and making everyday life easier. These e-books are free and will help free you from the burdens of arthritis. Go to <https://www.arthritis.org/liveyes/expert-advice>.*

Rebecca:

In our listener segment, we like to pose a question on social media or ask for tips and suggestions of how people manage a certain aspect of arthritis. And in this segment, we asked: How has arthritis in your feet and ankles affected your daily life? And between Instagram and Facebook, we literally got over 150 comments.

Dr. Cushman:  
Wow.

Rebecca:

It was a little crazy. (laughs) I've never seen that much activity, but you know what? I totally get it. Because early on in my mid-20s, I had to give up the fun shoes. Fun and fashionable shoes are not part of my vocabulary and have not been for 20 some years, because then it affects my knee and it affects my feet and I go for comfort, right? So, I get it.

One I wanna share is from one of our friends of the Foundation. He actually has guest co-hosted, who has rheumatoid arthritis, Pete Scalia is his name. He says: Out of all of it, he's had new knees, new hips, even deformity in his hands from his RA. He says his feet are the worst. Both arches collapsed. "All of my toes overlap. It's incredibly painful to stand for any amount, for any amount of time." And he's been putting off reconstructive surgery for a number of reasons. But also fear we talked about earlier: that reconstruction wouldn't take. Is there any advice you have for that?

Dr. Cushman:

I would say, first of all, I tell my patients: I would recommend you get this surgery as an example. I always say the same thing to them. I say any foot surgery is going to take longer to recover than you think it is. When you don't use your feet, it's really hard to live



your life. And there's risks to any surgery. So those to me are the three things that haven't answered your question yet. I think those are the things to keep in mind.

Now saying that, there are some surgeries that are a bit of a slam dunk. You say: You know what, the surgeons do this so commonly, it's got a very low recurrence rate of pain; it's got a very low risk of complications. If it was me, I would do it. And I would tell the patient that and be very clear: There are other surgeries where I would say, you know what, this one is a harder surgery. It's not done as commonly. We don't know it as well. It's definitely got a little bit more of a risk that it might not help. And I might even put a percentage on it, say, you know what, but there's a 90% chance that this will do really well, but you don't wanna be one of those 10%.

I would kind of think about it more as a timeline and goals. And if you know that timeline going in, the surgeon will be able to tell you: It's gonna take this long where you're not bearing weight on it, but this long where you're on crutches or whatever it may be. And at the end of all that, assuming everything goes well, which most of the time they do, will you be able to do what you wanna do at the end of it? And I would say for most patients, when they look at it that way, they're like: "OK, that is worth it to me to have that downtime and then be able to do what I wanna do."

Rebecca:

There's another person who... I know you look at non-operative treatments... One person says they're starting acupuncture on their feet and wanting to see if that works.

Dr. Cushman:

Acupuncture is an interesting thing where there is really reasonably good science showing that it works. The problem with it is that people like myself are not trained in it. And we have a totally different philosophy. We look at things differently. For me, I joke around: If I can't see it moving, I don't understand it. And I think that, for acupuncture, it's based on a different philosophy. But it's been proven to work. I think there's a couple things to consider for it.

Number one: There's very little evidence ever of people getting hurt by it. To me, if somebody says, "I wanna try it..." One thing I could say is there is virtually no risk to trying it. Second thing is: It does seem to be person-dependent. I've had many, many patients who say it helped. "I don't know why it helped, but it helped." And then the third thing to me is: What are your other options? I tend to look at things as a risk/benefit. And I always tend to err on the side of risk; I just don't wanna make





someone worse. That's just how I feel about every patient I see. If somebody says, "I wanna try acupuncture," I always say, "Try it."

PROMO:

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Rebecca:

Dr. Cushman, what are some of your top three takeaways for people dealing with foot or ankle pain from arthritis?

Dr. Cushman:

I would always try to avoid surgery first. I think, in general, no matter what your problem is with the foot, with the exception of some acute injuries: Try to avoid surgery. There will be some issues where people will come in to me, and I will say, "No, you need to do surgery, because you will do better; and if you don't, you will be much worse." So, I would say, with the exception of a few things, generally surgery should be a second- or third-line option. That would be number one.

Number two would be for osteoarthritis: Losing weight, if you're overweight, can be very helpful. Now, again, that is not every patient. And I fully understand that. But for patients who have some extra weight, that alone will only benefit your body. So, I think that's gonna be a huge help for some patients.

And then I think the third takeaway that I would say, just to encompass everything, and I hope I've hit on it a lot, is: One patient is different than the next. One patient's osteoarthritis of their ankle joint is different than another patient's osteoarthritis of their ankle joint. Just because a friend had an issue, it doesn't mean the treatment's gonna be the same for you.

It really depends on who you are, what you do, what your goals are, what your foot is like, what it's shaped like, what demands are placed on it, what your knee is like, what your hip is like and what you have done before and what you would like to do. I think trying to look at it from an algorithm or a one-size-fits-all approach just does not work. It's better to find out who you are and what you need.

Rebecca:



Yes, pain is a personal experience. And I agree with all of your takeaways. I think those are great ones to share. And also, as an occupational therapist myself, and a patient, the domino effect that can happen to the rest of your joints in your body, because you have foot pain, is not gonna help the rest of your body or the rest of your arthritis condition. Certainly, address any issues you have with pain in your feet and ankles. Talk about it with your doctor, get referrals from people that you know. Thank you so much for joining me today, Dr. Cushman, it's been very enlightening.

Dr. Cushman:

Good. I'm glad I could help.

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